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Transcribed Speech of Jane Reister Conard

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Transcribed Speech of Jane Reister Conard

MS. CONARD: I'm going to do my best to give you some background so that you will understand the context from which I am speaking. [I will also] try to respond and comment on what our two keynote speakers said this morning. It seems to me that they were looking at the macro view, so I'm going to narrow it down and give you my response from my basis representing one integrated health care system.

Intermountain Health Care [IHC] is a unique system. It's a not-for-profit integrated health care system and Sandy very kindly gave you some information about it. It originated in 1975 when the Church of Jesus Christ of Latter-day Saints [LDS] donated its fifteen-hospital system to the communities that those hospitals served. It is governed by a volunteer board of trustees and has grown now to be twenty-two hospitals. Although, of course, in that time frame, hospital services aren't really the focus as much anymore, it's more [of an] ambulatory care and total health care system [now].

In 2004, IHC had total revenues of \$2.7 billion and charity care was provided [for more than] 147,000 cases at a direct cost of \$67.3 million. That's excluding bad debt and that's not counting the total gift to the community, which included \$15 million for nursing education and physician residency programs. IHC is very much guided by its mission and, in that sense, I think it is similar to large Catholic hospital systems. IHC's mission is excellence in the provision of health care services - the best clinical practice delivered in a consistent and integrated way. And so that ties in a lot to what we are talking about this morning: the cost and quality of health care.

At Intermountain Health Care, there is the IHC Institute for Health Care Delivery Research, which Dr. Brent James founded. His focus has been to demonstrate [that] quality does pay. Now, in order to implement a lot of the recommendations from the Institute, it was necessary for Intermountain Health Care to promote cultural change, which Dr. James describes as moving from craft-based medical practice where you have the individual physician working alone to assess the needs of each individual patient, to what he calls profession-based medical practice consisting of groups of peers treating similar patients in a shared setting, planning coordinated care and delivery processes through those delivery processes or best practices or protocols. The result is less expensive than the traditional practice of

medicine because the facility can staff, train, and supply for a single core process, and the result is fewer mistakes, less conflict, and better patient outcomes.

Care delivery processes are developed through three methods. The first is the QUE studies, which stands for Quality, Utilization, and Evaluation. [I]ndividual physicians were compared anonymously to their peers. For example, [in] one surgical practice, how fast did the patient begin ambulatory status? How soon were catheters removed? What was the average length of stay? And so forth. And through the variations, after physicians saw how they compared, then slowly the variations lessened and there was an improvement in quality. So, that's the first sort of development of care delivery processes.

[P]ractice protocols can also be developed from research studies. A famous one was the use of antibiotics prior to surgery, prophylactic antibiotics. LDS Hospital did that years ago; now that's one of the measurements that JCAHO is advocating.

Finally, [there is] computerized physician support. Intermountain Health Care is a leader in that area and there's a whole informatics department. One of the best examples is, in terms of medications, there are built-in systems to avoid adverse drug events by comparing all of the medications a patient may be taking. [T]here's a program called Antibiotic Assist that will automatically present to the physician the optimal drug in the particular situation, what the optimum drugs are, and then the physician determines what should be prescribed in a particular case. This whole process is called "mass customization of care."

Based on these protocols, IHC has determined [first] that they produced better outcomes for patients; second, elimination of waste, reduction of cost, and an increase in available resources for patient care; and finally, an appropriate emphasis on the caring professions and control of care. Instead of the anonymous HMO manager, you have the physicians who are in charge. [A] lot of this has been promoted by the use of electronic data, which is very important in patient care delivery. However, this required quite a change in culture and I think [that] the fact that Intermountain Health Care is an integrated system made this possible. [I]n Dr. Brennan's writing, he refers to this as channeling.

Now, if I could back up just a little, I did borrow one slide from a presentation that Dr. James does and this is to demonstrate that the care protocols can result in cost savings. And as a matter of fact, Dr. James told me that in 2004, there was a \$3 million investment in his institute and in IHC's care practice management efforts. [B]ased on that \$3 million investment, IHC was able to measure and reduce by \$15 million its variable cost in providing care. [O]ne of Dr. James' favorite phrases is that by

managing clinical processes, we can do well by doing good.

[W]hat this results in, then, is a shared cultural situation where the hospital administrators and the physicians are working together to manage cost. [T]here is a great deal of physician involvement. Intermountain Health Care pays not only its employed physicians for attending meetings and so forth, but we also pay physicians who are on staff who are independent to participate in these clinical groups.

[F]or that matter, the whole management of Intermountain Health Care has been redesigned so that, in terms of overall corporate goals for the year, there are usually about two or three of those [goals that] are going to be care measurements. [This ensures against] the parallel approach of the administrators managing the facilities and trying to save money by their purchasing processes. Our support staff and the legal department is very unhappy because there are new purchasing processes and they can't order the kind of file folders they used to order because we only have 150 specific items that can be ordered without getting an exception, a change order sort of process. [T]hose are some of the efforts on the management side.

[O]n the clinical side, by having best practices there's been a focus on standardizing. [Y]ou can train your staff, you can order specific medical equipment or devices or pharmaceuticals, and it all becomes tied together. [T]he bottom line is savings; and the bottom line, even in terms of management accountability, depends on both of these parameters, or constructs, working together.

Compensation at Intermountain Health Care is determined by looking at comparable organizations and determining the median. [T]hen that [number] is reduced by 10% because we are not-for-profit, and then 25% of an executive's compensation is at risk and that's based on meeting the corporate goals. [I]n terms of corporate goals, as I mentioned earlier, two or three of the ten [goals] are related to care process management and that involves the electronic health record [and] a number of initiatives in that area. So when it comes down to that 25% at-risk compensation, a third of that is directly related to the clinical outcomes. So, the hospital administrator has accountability and is concerned about the care outcomes.

In terms of the legal aspect of this, now that I've given you some of the background and the context of Intermountain Health Care, I want to respond to what has been stated this morning. Professor Blum said that what we need [are] health goals integrated with delivery system goals. [T]hat is, in effect, what Intermountain Health Care is trying to do in terms of having a lower length of stay and fewer complications. This is, in part, the patient safety movement, but it is also based on effectiveness and outcomes.

[T]his leads to what Dr. Brennan was saying: does health law help in any

of the challenges that are facing the health care system? How does regulation affect all of this? My personal view is that some of the JCAHO initiatives are based on patient safety, the right location of surgery, and so forth. That is helpful and important, but to a certain extent, it doesn't focus on effectiveness the way some of the care processes have demonstrated greater effectiveness. So I guess you have good regulation and bad regulation, or superfluous regulation, or common sense sorts of things - which is not to denigrate what the JCAHO is doing, but it does get to be a bit bureaucratic.

In terms of the types of law that Dr. Brennan was talking about, in some ways, I view these as barriers. I guess it's because it's my perspective as in-house counsel. I'm one of those people who say[s], "Here is the law. Now tell me what you want to do and I will tell you how you can do it," particularly in the area of fraud and abuse.

In terms of the particular areas that Dr. Brennan mentioned, it was antitrust, non-profit law, fraud and abuse, torts and contracts, and then technology and regulation of technology. Antitrust is a huge challenge to Intermountain Health Care because it is a very large organization in two small states. Unfortunately, Intermountain Health Care has been referred to by its competitors as the "evil empire." [D]espite the fact that Intermountain Health Care has been named the top integrated system in the country, it certainly has its detractors locally. In the last session of the Utah legislat[ure], there was a bill that [suggested] any private, non-profit organization that owned hospitals and insurance companies should be required to divest the insurance company. Well, there's only one of those in Utah. And while that legislation was not successful, it was referred to a task force study that Intermountain Health Care is working with through this year. Our legal department was expanded by two FTEs [full-time employees] in order to respond to this. We do a lot of lobbying and a lot of education these days. In terms of non-profit status, there have been lawsuits within the state. It began with a property tax challenge way back in the '80s and so we do track all of our donations and give to the community.

Fraud and abuse is a real challenge. Stark Law is a thorn in my side and it probably is for many other lawyers practicing. We believe, and this may be reflecting my bias, but we believe that a lot of the impetus behind the effort to break up Intermountain Health Care comes from some of the entrepreneurial physicians in the state who have set up imaging centers and surgical centers. [O]f course, Intermountain Health Care has said [that] we have a managed care system and we have only certain facilities that will participate in that managed care system and those facilities are owned by Intermountain Health Care, or very closely aligned. [S]ince Intermountain

Health Care has about a third of the insureds' covered lives, in Utah that means that these entrepreneurial freestanding centers don't have access to a lot of insured patients. [T]hat is part of the impetus to break up Intermountain Health Care.

[A]nother example of where regulation can get in the way of things is in regard to medical informatics, the development of electronic health care record, and so forth. Stark prohibits any compensation or value over \$300 a year in terms of [a] financial relationship between a hospital and an individual physician. Well, in order to allow physicians to have access to electronic medical records for the continuum of care from the office site to the hospital, physicians have to be involved. [The] Secretary [of Health and Human Services Michael] Leavitt, who happens to be a former governor of Utah, has gotten a lot of communication, a lot of lobbying from Intermountain Health Care and other major organizations, including the Cleveland Clinic and some others, to try to develop an exception to that. [W]e are looking forward to that.

[T]o sum up, I would say in the trenches, if you will, there are a lot of pitfalls for the unwary. [T]hat is why Intermountain Health Care, which is a large integrated system but probably small in comparison to the wider context of the national health care scene, does have ten lawyers working full time to try to deal with the legal barriers and restrictions on how we do business.

[O]ne point I didn't get to in my time that's up now is how the care processes have been successful in reducing our medical malpractice challenges. [W]e think that they are successful, but it's terrifically difficult to isolate causative factors in that area. In the materials that I submitted, there is some discussion of that. I look forward to having further discussion with you at the end of this session.

Thank you.